Before the
Federal Communications Commission
Washington, D.C. 20554

In the Matter of	)	
	)	
Rural Health Care Support Mechanism	)	WC Docket No. 02-60

Our telecommunications company has been actively supporting the healthcare industry for 20 years. Since the passage of the 1996 Telecommunications Act, we have exclusively focused on the needs of healthcare provider.

All of our healthcare customers participate in the Rural Healthcare Mechanism. Whether rural or urban, these healthcare providers are in need of telecommunications and broadband services that give them access to the healthcare services their community needs.

Current Funding Levels

The Commission has pointed out that this $400 million fund has historically been underutilized. However, the reason for this underutilization is not only infrastructure needs in rural America. I believe infrastructure is not one of the top 5 reasons for the underutilization. Frankly, the telecommunications infrastructure has not been a factor in virtually all of the networks for our customers. Using today's technology we have delivered everything from T1, DS3, 10MB or higher Ethernet services. We have had just one instance of a problem in 2007 with a microwave problem in Idaho.

Our customers are located throughout rural America. Not one region is ahead of another when it comes to service availability. Whether it is terrestrial copper, coax or fiber, WiMAX, Satellite and more, there are solutions available today to provide the constituents of rural America bandwidths that exceed the 4MB benchmark outlined in the Commission's NPRM.

Historically, there are over 7,000 healthcare providers that have filed for inclusion in the Rural Healthcare Mechanism. Rightly pointed out in the commission's NPRM, only about 3,000 providers participate in the program annually. Our 10 year experience in working with healthcare providers using this fund has shown that the underutilization of this fund is based upon the following:

1. Outreach and Training:
    a. Providers believe that this program is cumbersome in nature and find that it is not worth the funding to expend the time to be involved. These providers are unaware of the ease of the process. This lack of awareness continues even though the Administrator has implemented needed changes under the direction of the Commission. Please know that these healthcare workers are focused on providing their community the best healthcare they

can. The perception is that it will take time away from the performance of their work.

b. Providers did not take full advantage of the available funding. Paperwork is consistently completed without a full understanding of the true funding amount. This combined with the Administrator's focus on more of a compliance based interaction with the provider means that there is a large amount of funding unused for existing funding requests. These providers could obtain significantly higher funding if they fully understood their telecommunications choices.

2. Provider personnel turnover:
    a. As a reference to the above 7,000+ providers that have filed for participation throughout the life of this program, a surprising number of the providers that are no longer active in the program are due to personnel issues. The contact that handled the program interface is no longer with the organization and the expertise has left the provider with no person to back fill that role.
3. IT Skillset:
    a. The program currently has a defined separation of responsibilities between the healthcare providers and service providers. This causes the healthcare provider to be reliant more upon their own skills to manage much of the technical and administrative process. Access to skillset is probably the number one issue for all of rural America. And this access to IT skillset is as acute as the significant problem of healthcare worker specialties. These providers must currently take responsibility to engage a service provider or other entity to support them as they complete the appropriate filing requirements. Without support, help and facilitation from the service provider, many times, the healthcare provider considers the work not worth the effort and will not move to completion.
    b. Consultants have been there to help fill this administrative role. However in most cases this same consultant is not the technical leader of a project and a significant void occurs in assisting the healthcare provider in evaluating the network needs of the provider. This lack of technical understanding significantly affects the amount of funding a healthcare provider may obtain.

4. Financial risk:
    a. The normal series of events when a healthcare provider begins utilizing the program is to, simultaneously, finalize funding approval through the form 466 process and install the service. Healthcare providers are fearful that they could find themselves with a multiyear contract for services which are not approved. Given many rural health care providers financial situation this can be disastrous. To avoid this risk, health care providers will simply do without the services they, in fact, desperately need.

HEALTH INFRASTRUCTURE PROGRAM:

I enthusiastically welcome the Commission's attempt to "jump-start" program utilization. Our company mission is to assist our healthcare provider perform the best healthcare service they can to their community. The implementation of a Health Infrastructure Program is a very bold step in the right direction. Rural healthcare and all of rural America needs the support of programs like these to keep pace with life in the "information age."

However I am concerned with the Commission's expectation that these healthcare providers or consortiums can be placed in a position to take on the management of what a Health Infrastructure Program project requires. It is imperative that the Commission fully understand that very few of these 9,800 eligible healthcare providers are in a position to take on the responsibilities of full control of the administration, implementation, service and maintenance of a telecommunications broadband network requires.

I believe that the result of the Pilot Program is a mix of success and missed opportunities for healthcare providers. The Pilot Program has, in many cases, funded un-necessary telecommunications network redundancies. Some projects are actually laying fiber along fiber routes currently used and available by telecommunications carriers, cable operators and others. Is this cost of network duplication something that is in the public interest? Funding multiple private health infrastructures throughout rural America may be un-necessary. Furthermore, the funding of exclusive "health infrastructure" in rural areas that do not make bandwidth available to other community businesses and consumers is a waste of resources. To reduce any duplication, it is imperative that the FCC, NTIA and HHS are together in understanding what networks are to be funded in these rural areas.

If there is to be funding available for "health infrastructure," it is appropriate that the health infrastructure program be expanded to somehow include the neighboring businesses and consumers. These businesses and consumers can pay for their portion of this network usage and it can easily be accounted for.

Project Selection Phase:
It is important to place a limit on the number of projects in a given year. The Administrator is not in a position to support the unique needs of a good number of individual projects.

I believe that the prioritization rules should apply to most in need. Critical access hospitals throughout rural America are in dire need of access to technology. These hospitals service an integral role in the communities and many work in conjunction with the local community health centers. These community health centers are the first line of healthcare for rural America. My recommendation is that we address these entities first.

Project Commitment Phase:
I concur with most details recommended by the commission. However, it is my belief that full ownership of such a network should not be held by the healthcare provider or consortium. See my response in the Consortium Applications section.

Connectivity Speed:
Current speed availability in rural America exceeds the minimums of 4Mbps and 10Mbps or more. If these networks are to be newly built, then these speeds will certainly be met and there is no need for setting a threshold requirement.

Setting minimum standards of quality and reliability should be included in each proposed network. Since these networks serve as an umbilical cord to skilled healthcare resources, it is imperative that these networks have continuous connectivity to perform disaster recovery and other quality and reliability standards. Not to mention that "cloud computing" technology is quickly becoming the most important IT infrastructure advancement for rural America, reliable access will be required.

Consortium Applications:
It is my belief that a Health Infrastructure Program should include provisions that offer technology partnerships. Healthcare providers and consortiums are not in a position to administer, install, service and maintain these networks. In light of my position stated above, that if an infrastructure were to be built in a rural community it should be a shared resource, I feel that a partnership or other arrangement should be made.

For example; many states have sponsored programs that have funded exclusive broadband access to schools. Many of these networks were delivered to the schools at speeds in excess of 100MB. These networks have additional capacity that can serve other members of these communities. In many cases these rural communities have this 100MB infrastructure serving the school with unacceptable or no broadband access for the community!

These partnerships can go further to include traditional healthcare providers, technology partners and the more skilled healthcare services businesses. It is a very good proposal to include Skilled Nursing Healthcare with funding support. The unique needs of the people in Rural America mean that healthcare services such as home healthcare should also be included.

Costs for healthcare can be significantly reduced by keeping people in their communities receiving the highest care possible. Telemedicine technologies such as televideo can make it much easier to provide care without the additional burden of clinic or hospital visits. Home healthcare can provide an important service with the use of televideo to the home. Teleradiology applications provide these rural healthcare professionals with access to the most skilled radiologists in the world. I believe that connectivity to home healthcare, radiology firms and other entities should be included as well.

HEALTH BROADBAND SERVICE PROGRAM

I fully support the establishment of a 50% discount for eligible rural healthcare providers.

Because rural America is relying heavily upon the connectivity to the backbone network, minimum levels of reliability and physical redundancy should be required. Standards for connectivity should include diverse route, diverse carrier, diverse terminating network/equipment interfaces.

It is important to include a 50% discount funding for installation costs. I support the funding of non-recurring charges as currently offered in the schools and libraries support mechanism. It is sufficient that all non-recurring charges of more than $500,000 must be part of a multi-year contract and must be prorated over a period of five years.

Restrictions on Satellite Services:
Satellite will play a very important role in providing disaster recovery to rural America. Costs for this technology are such that bandwidths will be limiting. However, satellite delivery is vital to help the rural healthcare provider with a diverse and redundant connection.

Launching satellites are not an option for rural healthcare providers. So, it seems that access to this technology must be through satellite companies that support end users. This technology offers the unique feature of total redundancy. I do not believe that a healthcare provider should be limited to receive funding that is capped at the amount that the provider would have received if they purchased a functionally similar terrestrial-based alternative. Some satellite installations can be placed at a data center or hub-site that may cost more than the functionally similar terrestrial-based alternative. Because this is an aggregation site that serves multiple sites, I recommend that there be a limit to the number of data centers or hub-sites funded on a network. If directives from HHS require disaster recovery mechanisms in the network, that limit should be set at 2 hub-sites or data centers. This would be adequate in case of network failures.

Level of Support:
The current urban/rural rate formula is a fair standard. Our experience under the existing telecommunications program is that funding commitments are slightly higher than 80% for T-1 lines. When we review the comparative costs for higher bandwidths such as Ethernet speeds, we find a comparable level of funding amounts.

A flat discount for larger bandwidths of 50% is not acceptable. Delivery of these larger bandwidths is not a problem to rural America. The problem is cost! I would recommend the same rural/urban rate formula could be used as a standard.

Competitive Bidding:
It is not necessary to make any changes to the current form 465 posting process. However, it is imperative that changes be made to the processing of the form 466 funding requests. In an effort to streamline a currently cumbersome and time consuming process, I would like to see the Administrator implement a “fast track” approval process for all form 466 funding requests that are deemed to have evergreen (services that have already been approved during the prior funding year) status. Timely funding for healthcare providers is imperative. Since these form 466s have evergreen status, the Administrator

should not require the more rigorous review of funding packets for a service that was previously approved and funded.

ELIGIBLE HEALTHCARE PROVIDERS

Administrative Offices
It is our recommendation to include healthcare administrative offices as eligible for funding. Many community healthcare providers do not own their buildings, so we do not recommend that any ownership requirements be made. If the telecommunications or internet service is being used in the service of healthcare, of which healthcare administrative offices play an important role, then funding should be available.

Data Centers
It is our recommendation to include off-site data centers as eligible for funding, only if the telecom service that is funded is being used in the service of healthcare. Like an administrative office, it is not necessary to require that the physical building be the qualifier in determining the funding eligibility. It is only necessary that the telecom service is used for healthcare purposes.

Skilled Nursing Facilities
As mentioned above, Skilled nursing facility should be considered eligible for rural health care support. If the facility is providing services covered by Medicare, Universal Service funding should be available.

Renal Dialysis Centers and Facilities
These facilities should be included.

ANNUAL CAPS AND PRIORITIZATION RULES

If a Health Infrastructure Program is implemented a cap on funding must be included. The limits put forth in the Commission's NPRM are satisfactory. However, if funding for the health broadband services program becomes limited due to caps being met, the Health Infrastructure Program must not take away from the funding of the health broadband services program.

I fully support a set aside funding amount that can demonstrate innovative uses of broadband connectivity to meet health care needs in a community of up to $5 million annually. This set aside can play a vital role in supporting unique tests of which the commission and other agencies can gain important feedback.

Offset Rule
Service provider access to funds in a timely manner is extremely important to the healthcare provider.

We recommend that all service providers have the option for USF contribution offsets. However, I believe that it is important to have a distinction between an eligible

telecommunications carrier and other service providers in this program. This is a federal program, yet it is important to make adjustments based upon many state certification requirements. Many states continue to regulate our industry. It may place the healthcare provider in a precarious position of obtaining service from a service provider that may not have the appropriate state certifications. The burden of proof is placed upon the healthcare provider to determine the carrier's eligibility. With the help of the federal distinction of eligible telecommunications carrier that contributes to the Universal Service Fund, a healthcare provider will more likely have the confidence that the status of a service provider is appropriate at the state level.

Data Gathering and Analysis
I fully support the creation of a working group that provides critical information to the Commission to develop recommendations for the direction of the Rural Health Care Support Mechanism. Participants should include, eligible healthcare providers, service providers, USAC and Commission representatives.

Respectfully submitted,

Tim Koxlien
CEO
TeleQuality Communications, Inc.

*electronic submission